Colorado Medicaid Prior Authorization Request Form

Sovaldi (sofosbuvir) or Harvoni (sofosbuvir and ledipasvir)

This form **must be signed by prescriber** to request prior authorization for Sovaldi or Harvoni beginning October 1, 2015. See the Preferred Drug List (PDL) for details at: https://www.colorado.gov/hcpf/provider-forms. Certain documentation is required to accompany this form for approval consideration. Prescriber must be a physician and must complete and sign this form.

Please fill in ALL areas on form. Incomplete forms (including missing required lab values or documentation) will result in a PA denial

Select drug you are requesting: □ **Sovaldi** □ **Harvoni**

Member name: _____ DOB: _____

Medicaid ID: _____ Gender: _____ BMI: _____ CrCl ml/min: _____

This section must be complete AND all documentation must accompany PAR or PA will be denied for incompleteness

Genotype: □ 1a □ 1b (**Harvoni only**) □ 2 □ 3 □ 4

Child-Pugh Score: _____ (5-9, not A or B) Pre-tx HCV RNA IU/mL: _____ Hep A&B vaccination series □ Completed □ In Progress (provide labs/immunization record)

Any fibrosis? (**must provide labs and show calculation for APRI/FIB-4/FibroScan/FibroMeter/FibroTest**) □ No □ Yes

Provide scores: Biopsy_____ APRI_____ FIB-4 _____ FibroScan_____ FibroMeter/FibroTest _____

Approvable scores: F3 - F4 >1 >2.2 >9.6kPa >0.58kPa

Provider attests that member is ready to be compliant to the medication regimen □ Yes

Provider attests that SVR12 and SVR24 will be submitted timely via fax □ Yes

History of drug/alcohol misuse/abuse? □ No □ Yes

Has member been drug/alcohol free for at least 6 months? □ No □ Yes

Attached screens (not more than 30 days old) □ Marijuana □ Toxicology □ ETOH

ALL members must provide initial drug/alcohol screen documentation which must include marijuana. Provide random monthly screens during treatment if member has **history of misuse/abuse within last 2 years**

Prior Treatment: □ No □ Yes **Describe with approximate dates**: _____

Indicate member's diagnosis(es) (provide documentation):

□ Chronic Hepatitis C □ Hepatitis B □ Cirrhosis: □ CTP A □ CTP B (must be on transplant list)
□ HIV/AIDS □ Post-transplant □ On transplant list with less than 1 year on the list projected
□ Ascites □ Variceal bleed □ Hepatic encephalopathy □ Leukocytoclastic vasculitis
□ Membranoproliferative glomerulonephritis □ Symptomatic cryogobulinemia despite mild liver disease
□ Hepatocellular carcinoma meeting Milan criteria □ Severe renal impairment (eGFR< 30mL/min)

For Sovaldi only: Peginterferon alfa □ Eligible □ Ineligible* Describe: _____

*Defined as: Platelet count <75,000mm^3; CTP Class B/C; Uncontrolled mood disorder or history of psychosis; Autoimmune hepatitis and another autoimmune disorder; Documented interferon-related adverse event - (Provide documentation)

Complete current medication list required. Attached? □ Yes

Is member taking (circle) amiodarone, carbamazepine, phenytoin, phenobarbital, oxcarbazepine, rifampin, rifabutin, rifapentine, St. John's wort, tipranavir/ritonavir, elvitegravir*, cobicistat*, emtricitabine*, tenofovir*, simepravir,*, rosuvastatin* (*Harvoni only)

□ **None**

Female members: Is member of childbearing potential? □ No □ Yes (provide pregnancy test)

Is requested drug being prescribed in conjunction with an infectious disease specialist, gastroenterologist, or hepatologist?
□ No □ Yes Identify provider and specialty (circle above): _____

Initial approval: 8 week supply. Refills: not granted unless required documentation is received.

Physician: _____ Phone: _____ Fax: _____ NPI: _____

Physician signature: _____ Date: _____

(Must be signed by PHYSICIAN for attestation)

Effective January 1, 2016 **Please fax completed form and supporting documentation to 888-772-9696**